



Texas Department of Insurance

Division of Workers' Compensation

Medical Fee Dispute Resolution, MS-48

7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645

518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

IRVING COPPELL SURGICAL HOSPITAL
440 W I-635
IRVING TX 75063

DWC Claim #:
Injured Employee:
Date of Injury:
Employer Name:
Insurance Carrier #:

Respondent Name

LIBERTY INSURANCE CORP

Carrier's Austin Representative Box

Box Number 01

MFDR Tracking Number

M4-09-7182-01

MFDR Date Received

MARCH 24, 2009

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "As we have established on numerous occasions the amount of reimbursement in accordance with the Act in conjunction with medical coding and billing, requestor remains in the position that payment was not made accordingly, we uphold our request for additional reimbursement in the amount of \$9695.84 in addition to penalty interest for the claims processing error."

Amount in Dispute: \$9,695.84

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Liberty Mutual believes that Irving Coppel Surgical Hospital has been appropriately reimbursed for services rendered..."

Response Submitted by: Liberty Mutual, 2875 Browns Bridge Road, Gainesville, TX 30504

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Services	Amount In Dispute	Amount Due
November 21, 2008	Outpatient Hospital Services	\$9,695.84	\$9,695.84

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.403, titled *Hospital Facility Fee Guideline – Outpatient*, sets out the reimbursement guidelines for facility services provided in an outpatient acute care hospital.
3. 28 Texas Administrative Code §134.203, titled *Medical Fee Guideline for Professional Services*, sets out the reimbursement for guidelines for professional medical services.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:

Explanation of benefits dated January 10, 2009:

- 150, X901 – Documentation does not support level of service billed.
- 150, Z652 – Recommendation of payment has been based on a procedure code which best describes services rendered.
- 97, X668 – Venipuncture charges are included in the global lab fees.
- 42, Z710 – The charge for this procedure exceeds the fee schedule allowance.

Issues

1. Did the respondent support the insurance carrier's reasons for reduction or denial of services?
2. Are the disputed services subject to a contractual agreement between the parties to this dispute?
3. What is the applicable rule for determining reimbursement for the disputed services?
4. What is the recommended payment amount for the services in dispute?
5. Is the requestor entitled to reimbursement?

Findings

1. The insurance carrier reduced or denied disputed services with reason code "150, X901 – Documentation does not support level of service billed." The respondent based its denial on the CMS-1500 submitted by the treating doctor, stating in part, that the surgical procedures that were performed were 64719 – Neuroplasty and/or transposition; the ulnar nerve is located and freed; 64721, the median nerve is decompressed by freeing the nerve inside the carpal tunnel. The provider billed 2645 – Synovectomy incorrectly because the physician already performed this procedure **while in the carpal tunnel**. These are not separate procedures as if they were, the surgeon who performed the surgery should have billed for them. The surgeon did not bill 26145 for this surgery." The requestor submitted a rebuttal that states "Respondent indicates provider billed... with medical descriptions provided accordingly; respondent then states on page 2 that the provider... billed 26145 Synovectomy incorrectly because the physician already performed this procedure while in the carpal tunnel... Please be advised, it is inappropriate to base our payment on the physician as we have not control in the physicians' choice in coding, our coders utilize the information presented to them and code accordingly... Regardless of same incision, the carpal tunnel is relative to the nerve and flexor tendons relative to the finger therefore these are distinct compartments and in accordance with Medicare CCI editing, these service do qualify for distinct and exclusive payment; in addition multiple laboratory services were provided as well with fee schedule payments not made according to TDI regulations and guidelines." The respondent has not supported their denial.
2. Review of the submitted documentation finds no information to support a contractual agreement between the parties to this dispute.
3. This dispute relates to facility services performed in an outpatient hospital setting with reimbursement subject to the provisions of 28 Texas Administrative Code §134.403, which requires that the reimbursement calculation used for establishing the maximum allowable reimbursement (MAR) shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Outpatient Prospective Payment System (OPPS) reimbursement formula and factors as published annually in the Federal Register with the application of minimal modifications as set forth in the rule. Per §134.403(f)(1), the sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 200 percent, unless a facility or surgical implant provider requests separate reimbursement of implantables. Review of the submitted documentation finds that separate reimbursement for implantables was not requested.
4. Under the Medicare Outpatient Prospective Payment System (OPPS), each billed service is assigned an Ambulatory Payment Classification (APC) based on the procedure code used, the supporting documentation and the other services that appear on the bill. A payment rate is established for each APC. Depending on the services provided, hospitals may be paid for more than one APC per encounter. Payment for ancillary and supportive items and services, including services that are billed without procedure codes, is packaged into payment for the primary service. A full list of APCs is published annually in the OPPS final rules which are publicly available through the Centers for Medicare and Medicaid Services (CMS) website. Reimbursement for the disputed services is calculated as follows:
 - Procedure code 25105 has a status indicator of T, which denotes a significant procedure subject to multiple procedure discounting. The highest paying status T APC is paid at 100%; all others are paid at 50%. This procedure is paid at 100%. This service is classified under APC 0050, which, per OPPS Addendum A, has a payment rate of \$1,859.23. This amount multiplied by 60% yields an unadjusted labor-related amount of \$1,115.54. This amount multiplied by the annual wage index for this facility of 0.9816 yields an adjusted labor-related amount of \$1,095.01. The non-labor related portion is 40% of the APC rate or \$743.69. The

sum of the labor and non-labor related amounts is \$1,838.70. The cost of this service does not exceed the annual fixed-dollar threshold of \$1,575. The outlier payment amount is \$0. The total APC payment for this service, including outliers and any multiple procedure discount, is \$1,838.70. This amount multiplied by 200% yields a MAR of \$3,677.41.

- Procedure code 26145 has a status indicator of T, which denotes a significant procedure subject to multiple procedure discounting. The highest paying status T APC is paid at 100%; all others are paid at 50%. This procedure is paid at 50%. This service is classified under APC 0053, which, per OPPS Addendum A, has a payment rate of \$1,048.64. This amount multiplied by 60% yields an unadjusted labor-related amount of \$629.18. This amount multiplied by the annual wage index for this facility of 0.9816 yields an adjusted labor-related amount of \$617.61. The non-labor related portion is 40% of the APC rate or \$419.46. The sum of the labor and non-labor related amounts is \$1,037.06. The cost of this service does not exceed the annual fixed-dollar threshold of \$1,575. The outlier payment amount is \$0. The total APC payment for this service, including outliers and any multiple procedure discount, is \$518.53. This amount multiplied by 200% yields a MAR of \$1,037.06.
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- Procedure code 64719 has a status indicator of T, which denotes a significant procedure subject to multiple procedure discounting. The highest paying status T APC is paid at 100%; all others are paid at 50%. This procedure is paid at 50%. This service is classified under APC 0220, which, per OPPS Addendum A, has a payment rate of \$1,149.79. This amount multiplied by 60% yields an unadjusted labor-related amount of \$689.87. This amount multiplied by the annual wage index for this facility of 0.9816 yields an adjusted labor-related amount of \$677.18. The non-labor related portion is 40% of the APC rate or \$459.92. The sum of the labor and non-labor related amounts is \$1,137.10. The cost of this service does not exceed the annual fixed-dollar threshold of \$1,575. The outlier payment amount is \$0. The total APC payment for this service, including outliers and any multiple procedure discount, is \$568.55. This amount multiplied by 200% yields a MAR of \$1,137.10.
- Procedure code 36415 has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Payment for this service is calculated according to §134.203, the Medical Fee Guideline for Professional Services. The fee listed for this code in the applicable Medicare fee schedule is \$3.00. 125% of this amount is \$3.75. The recommended payment is \$3.75.
- Procedure code 84295 has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Payment for this service is calculated according to §134.203, the Medical Fee Guideline for Professional Services. The fee listed for this code in the applicable Medicare fee schedule is \$6.72. 125% of this amount is \$8.40. The recommended payment is \$8.40.
- Procedure code 84132 has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Payment for this service is calculated according to §134.203, the Medical Fee Guideline for Professional Services. The fee listed for this code in the applicable Medicare fee schedule is \$6.42. 125% of this amount is \$8.03. The recommended payment is \$8.03.
- Procedure code 82435 has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the

applicable Division fee guideline in effect for that service on the date the service was provided. Payment for this service is calculated according to §134.203, the Medical Fee Guideline for Professional Services. The fee listed for this code in the applicable Medicare fee schedule is \$6.42. 125% of this amount is \$8.03. The recommended payment is \$8.03.

- Procedure code 84520 has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Payment for this service is calculated according to §134.203, the Medical Fee Guideline for Professional Services. The fee listed for this code in the applicable Medicare fee schedule is \$5.51. 125% of this amount is \$6.89. The recommended payment is \$6.89.
 - Procedure code 82947 has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Payment for this service is calculated according to §134.203, the Medical Fee Guideline for Professional Services. The fee listed for this code in the applicable Medicare fee schedule is \$5.48. 125% of this amount is \$6.85. The recommended payment is \$6.85.
 - Procedure code 85014 has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Payment for this service is calculated according to §134.203, the Medical Fee Guideline for Professional Services. The fee listed for this code in the applicable Medicare fee schedule is \$3.31. 125% of this amount is \$4.14. The recommended payment is \$4.14.
 - Procedure code 81025 has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Payment for this service is calculated according to §134.203, the Medical Fee Guideline for Professional Services. The fee listed for this code in the applicable Medicare fee schedule is \$8.84. 125% of this amount is \$11.05. The recommended payment is \$11.05.
 - Procedure code 81002 has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Payment for this service is calculated according to §134.203, the Medical Fee Guideline for Professional Services. The fee listed for this code in the applicable Medicare fee schedule is \$3.57. 125% of this amount is \$4.46. The recommended payment is \$4.46.
5. The total recommended payment for the services in dispute is \$13,172.60. This amount less the amount previously paid by the insurance carrier of \$2,355.06 leaves an amount due to the requestor of \$10,817.54. The requestor is seeking \$9,695.84. This amount is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is \$9,695.84.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of \$9,695.84, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

_____	_____	August 17, 2012
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision* together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party.****

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.